

## ENROLLMENT & EMERGENCY CONTACT INFORMATION

STUDENT'S LAST NAME                      FIRST                      MIDDLE                      Date of Birth

Address (Street)                      Apt. #                      City                      Zip                      Home Telephone Number (      )

Father  
 Stepfather  
 Guardian  
 Not in Home

Name                      Occupation

Cell Phone: (      )

Name of Employer                      Work Telephone (w/extension)

Mother  
 Stepmother  
 Guardian  
 Not in Home

Name                      Occupation

Cell Phone: (      )

Name of Employer                      Work Telephone (w/extension)

Out of State Disaster Contact:	
Name	(      ) Phone #

**EMERGENCY CONTACT INFORMATION**  
**EMERGENCY NUMBERS - MUST BE COMPLETED**

and only the people listed on this form will be permitted to pick up your child in the event of an emergency (earthquake, natural disaster, etc.), illness or injury. Any other persons must have written authorization from parent or guardian.

**PERSON RESPONSIBLE FOR CHILD:** \_\_\_\_\_

Please list EMERGENCY contacts name, telephone number, and relationship in the order you wish them to be called.

NAME	ADDRESS	TELEPHONE (with area code)	RELATIONSHIP

**ADDITIONAL CONTACT INFORMATION**

Names of additional persons authorized to take my child from the facility on a regular basis (i.e. carpools):

NAME	TELEPHONE (with area code)	RELATIONSHIP

Please name specific person(s) who may **NOT** take child away from school. If this person is the child's parent, a restraining order must be on file in the school office. \_\_\_\_\_

For Office Use Only:      Date enrolled:      Date left: \_\_\_\_\_

Los Altos Grace Preschool \* 6565 Stearns Street \* Long Beach, CA 90815 \* (562) 430-6813

### AUTHORIZATION FOR EMERGENCY CARE

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Initial

[ ] I hereby authorize Los Altos Grace Schools to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care, in case I am not immediately available. Any qualified physician called by Los Altos Grace Schools may treat and do whatever is necessary for the health and well-being of my child. It is understood that a conscientious effort must be made to notify us (parents) before such action will be taken. I also agree to accept responsibility for the cost of above medical services not covered by school insurance.

Doctors Name: \_\_\_\_\_ Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Name of Medical Insurance \_\_\_\_\_ ID Number \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Address \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Dental Insurance \_\_\_\_\_ ID Number \_\_\_\_\_

Does your child have any special/serious health problems? Yes  No  If yes, please explain: \_\_\_\_\_

Allergies to food: Yes  No  If yes, please list: \_\_\_\_\_

Allergies to environment: Yes  No  If yes, please list: \_\_\_\_\_

Allergies to medication: Yes  No  If yes, please list: \_\_\_\_\_

Name of Current Medications \_\_\_\_\_

Will your child be taking medication(s) at school? Yes  No  If yes, please list \_\_\_\_\_

A "Parent Consent for Administration of Medications" form must be on file in order for a medication to be administered at school.

Signatures: This form must have two signatures.

MOTHER/LEGAL GUARDIAN \_\_\_\_\_ Date \_\_\_\_\_

FATHER/LEGAL GUARDIAN \_\_\_\_\_ Date \_\_\_\_\_

It is our usual practice to release children to either parent. If, through custody, guardianship, or some other arrangement that places a restriction on one or both parent's ability to pick up their child from school, please provide the office with appropriate documentation of such arrangement.

## COVID-19 Illness Policy Update

Los Altos Grace Preschool has updated our Illness Policy as a result of Public Health Guidelines related to COVID-19 as follows:

Each morning, staff will administer a wellness check for each child. This wellness check will look for signs of illness including but not limited to:

- Respiratory symptoms
  - Nasal discharge
  - Congestion
  - Sneezing, coughing
- Other symptoms of illness such as
  - Conjunctivitis
  - Diarrhea, nausea, vomiting
  - Skin rash
- Temperature of or above 100.4

Staff will confirm with parents that during the last 24 hours, their child

- Has not been ill
- Has not been exposed to anyone that was ill
- Has not received any fever reducing medicine

If a child displays any of the above symptoms, they must stay home. If symptoms are displayed during the school day, the child will be isolated and must be picked up promptly.

If a child is home with any of these symptoms, they must be fever free and symptom free for 72 hours before returning to school.

Additionally, if the symptoms are consistent with COVID-19 (fever and/or cough) they must stay home for a minimum of 10 days after onset of symptoms AND until their symptoms have improved AND they are fever free for at least 72 hours without medication.

If a child has been exposed to someone with a respiratory illness, they should remain home for 14 days to see if they develop symptoms.

Please notify the school if someone in your household is suspected or has tested positive for COVID-19. In this case, your child must remain home for 14 days.

If a child or staff member tests positive for COVID-19, we will immediately contact the Department of Public Health and follow their recommendations. All staff and families will be notified of a confirmed case of COVID-19 in someone connected to our facility.

I have read and agree to this Illness Policy Update.

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Child's Name

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Parent Signature

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Date



## LOS ALTOS GRACE PRESCHOOL Admission Agreement

Please initial on each line below to acknowledge that you have read each point.

\_\_\_\_\_ I realize my responsibility to keep my child's tuition up to date. I understand that all tuition payments are due on the first of each month and delinquent after the tenth. I agree to pay a \$20.00 late fee for any tuition payment not received by the 10<sup>th</sup> of the month.

\_\_\_\_\_ I agree to pay a \$25.00 service charge in the event that my check is returned to the school by the bank because of insufficient funds.

\_\_\_\_\_ I have read the "Mark Your Calendar – Preschool Schedule" form and am aware of which days the school will be closed during the school year.

Child's Name \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

## PERSONAL RIGHTS

### Child Care Centers

Personal Rights, See Section 101223 for waiver conditions applicable to Child Care Centers.

- (a) Child Care Centers. Each child receiving services from a Child Care Center shall have rights which include, but are not limited to, the following:
- (1) To be accorded dignity in his/her personal relationships with staff and other persons.
  - (2) To be accorded safe, healthful and comfortable accommodations, furnishings and equipment to meet his/her needs.
  - (3) To be free from corporal or unusual punishment, infliction of pain, humiliation, intimidation, ridicule, coercion, threat, mental abuse, or other actions of a punitive nature, including but not limited to: interference with daily living functions, including eating, sleeping, or toileting; or withholding of shelter, clothing, medication or aids to physical functioning.
  - (4) To be informed, and to have his/her authorized representative, if any, informed by the licensee of the provisions of law regarding complaints including, but not limited to, the address and telephone number of the complaint receiving unit of the licensing agency and of information regarding confidentiality.
  - (5) To be free to attend religious services or activities of his/her choice and to have visits from the spiritual advisor of his/her choice. Attendance at religious services, either in or outside the facility, shall be on a completely voluntary basis. In Child Care Centers, decisions concerning attendance at religious services or visits from spiritual advisors shall be made by the parent(s), or guardian(s) of the child.
  - (6) Not to be locked in any room, building, or facility premises by day or night.
  - (7) Not to be placed in any restraining device, except a supportive restraint approved in advance by the licensing agency.

THE REPRESENTATIVE/PARENT/GUARDIAN HAS THE RIGHT TO BE INFORMED OF THE APPROPRIATE LICENSING AGENCY TO CONTACT REGARDING COMPLAINTS, WHICH IS:

NAME

Department of Social Services - L.A. Child Care East

ADDRESS

1000 Corporate Center Drive Suite 200 B

CITY

Monterey Park

ZIP CODE

91754

AREA CODE/TELEPHONE NUMBER

(323) 981-3374

DETACH HERE

**TO: PARENT/GUARDIAN/CHILD OR AUTHORIZED REPRESENTATIVE:**

**PLACE IN CHILD'S FILE**

Upon satisfactory and full disclosure of the personal rights as explained, complete the following acknowledgment:

**ACKNOWLEDGMENT:** I/We have been personally advised of, and have received a copy of the personal rights contained in the California Code of Regulations, Title 22, at the time of admission to:

(PRINT THE NAME OF THE FACILITY)

(PRINT THE ADDRESS OF THE FACILITY)

(PRINT THE NAME OF THE CHILD)

(SIGNATURE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(TITLE OF THE REPRESENTATIVE/PARENT/GUARDIAN)

(DATE)

# CONSENT FOR EMERGENCY MEDICAL TREATMENT- Child Care Centers Or Family Child Care Homes

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO

\_\_\_\_\_ TO OBTAIN ALL EMERGENCY MEDICAL OR DENTAL CARE  
FACILITY NAME

PRESCRIBED BY A DULY LICENSED PHYSICIAN (M.D.) OSTEOPATH (D.O.) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_. THIS CARE MAY BE GIVEN UNDER  
NAME

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD  
NAMED ABOVE.

CHILD HAS THE FOLLOWING MEDICATION ALLERGIES:

\_\_\_\_\_ DATE

\_\_\_\_\_ PARENT OR AUTHORIZED REPRESENTATIVE SIGNATURE

\_\_\_\_\_ HOME ADDRESS

HOME PHONE  
( )

WORK PHONE  
( )

# PHYSICIAN'S REPORT—CHILD CARE CENTERS (CHILD'S PRE-ADMISSION HEALTH EVALUATION)

## PART A – PARENT'S CONSENT (TO BE COMPLETED BY PARENT)

\_\_\_\_\_, born \_\_\_\_\_ is being studied for readiness to enter  
(NAME OF CHILD) (BIRTH DATE)

\_\_\_\_\_. This Child Care Center/School provides a program which extends from \_\_\_\_\_ : \_\_\_\_\_  
(NAME OF CHILD CARE CENTER/SCHOOL)

a.m./p.m. to \_\_\_\_\_ a.m./p.m. , \_\_\_\_\_ days a week.

Please provide a report on above-named child using the form below. I hereby authorize release of medical information contained in this report to the above-named Child Care Center.

\_\_\_\_\_  
(SIGNATURE OF PARENT, GUARDIAN, OR CHILD'S AUTHORIZED REPRESENTATIVE)

\_\_\_\_\_  
(TODAY'S DATE)

## PART B – PHYSICIAN'S REPORT (TO BE COMPLETED BY PHYSICIAN)

Problems of which you should be aware:

Hearing: \_\_\_\_\_ Allergies: medicine: \_\_\_\_\_  
Vision: \_\_\_\_\_ Insect stings: \_\_\_\_\_  
Developmental: \_\_\_\_\_ Food: \_\_\_\_\_  
Language/Speech: \_\_\_\_\_ Asthma: \_\_\_\_\_  
Dental: \_\_\_\_\_  
Other (Include behavioral concerns): \_\_\_\_\_  
Comments/Explanations: \_\_\_\_\_

MEDICATION PRESCRIBED/SPECIAL ROUTINES/RESTRICTIONS FOR THIS CHILD: \_\_\_\_\_

### IMMUNIZATION HISTORY: (Fill out or enclose California Immunization Record, PM-298.)

VACCINE	DATE EACH DOSE WAS GIVEN				
	1st	2nd	3rd	4th	5th
POLIO (OPV OR IPV)	/ /	/ /	/ /	/ /	/ /
DTP/DTaP/ DT/Td (DIPHTHERIA, TETANUS AND [ACELLULAR] PERTUSSIS OR TETANUS AND DIPHTHERIA ONLY)	/ /	/ /	/ /	/ /	/ /
MMR (MEASLES, MUMPS, AND RUBELLA)	/ /	/ /			
HIB MENINGITIS (REQUIRED FOR CHILD CARE ONLY) (HAEMOPHILUS B)	/ /	/ /	/ /	/ /	
HEPATITIS B	/ /	/ /	/ /		
VARICELLA (CHICKENPOX)	/ /	/ /	/ /		

#### SCREENING OF TB RISK FACTORS (listing on reverse side)

- Risk factors not present; TB skin test not required.
- Risk factors present; Mantoux TB skin test performed (unless previous positive skin test documented).
- \_\_\_ Communicable TB disease not present.

I have  have not  reviewed the above information with the parent/guardian.

Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone: \_\_\_\_\_

Date of Physical Exam: \_\_\_\_\_  
Date This Form Completed: \_\_\_\_\_  
Signature \_\_\_\_\_

Physician  Physician's Assistant  Nurse Practitioner

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**RISK FACTORS FOR TB IN CHILDREN:**

- \* Have a family member or contacts with a history of confirmed or suspected TB.
- \* Are in foreign-born families and from high-prevalence countries (Asia, Africa, Central and South America).
- \* Live in out-of-home placements.
- \* Have, or are suspected to have, HIV infection.
- \* Live with an adult with HIV seropositivity.
- \* Live with an adult who has been incarcerated in the last five years.
- \* Live among, or are frequently exposed to, individuals who are homeless, migrant farm workers, users of street drugs, or residents in nursing homes.
- \* Have abnormalities on chest X-ray suggestive of TB.
- \* Have clinical evidence of TB.

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Consult with your local health department's TB control program on any aspects of TB prevention and treatment.



**CHILD'S PREADMISSION HEALTH HISTORY—PARENT'S REPORT**

CHILD'S NAME	SEX	BIRTH DATE
FATHER'S NAME	DOES FATHER LIVE IN HOME WITH CHILD?	
MOTHER'S NAME	DOES MOTHER LIVE IN HOME WITH CHILD?	
IS /HAS CHILD BEEN UNDER REGULAR SUPERVISION OF PHYSICIAN?	DATE OF LAST PHYSICAL/MEDICAL EXAMINATION	

**DEVELOPMENTAL HISTORY** (\*For infants and preschool-age children only)

WALKED AT*	MONTHS	BEGAN TALKING AT*	MONTHS	TOILET TRAINING STARTED AT*	MONTHS
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**PAST ILLNESSES — Check illnesses that child has had and specify approximate dates of illnesses:**

	DATES		DATES		DATES
<input type="checkbox"/> Chicken Pox		<input type="checkbox"/> Diabetes		<input type="checkbox"/> Poliomyelitis	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Epilepsy		<input type="checkbox"/> Ten-Day Measles (Rubeola)	
<input type="checkbox"/> Rheumatic Fever		<input type="checkbox"/> Whooping cough		<input type="checkbox"/> Three-Day Measles (Rubella)	
<input type="checkbox"/> Hay Fever		<input type="checkbox"/> Mumps			

SPECIFY ANY OTHER SERIOUS OR SEVERE ILLNESSES OR ACCIDENTS

DOES CHILD HAVE FREQUENT COLDS? <input type="checkbox"/> YES <input type="checkbox"/> NO	HOW MANY IN LAST YEAR?	LIST ANY ALLERGIES STAFF SHOULD BE AWARE OF
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**DAILY ROUTINES** (\*For infants and preschool-age children only)

WHAT TIME DOES CHILD GET UP?*	WHAT TIME DOES CHILD GO TO BED?*	DOES CHILD SLEEP WELL?*
DOES CHILD SLEEP DURING THE DAY?*	WHEN?*	HOW LONG?*
DIET PATTERN: (What does child usually eat for these meals?)	BREAKFAST LUNCH DINNER	WHAT ARE USUAL EATING HOURS? BREAKFAST _____ LUNCH _____ DINNER _____

ANY FOOD DISLIKES? ANY EATING PROBLEMS?

IS CHILD TOILET TRAINED?*	IF YES, AT WHAT STAGE:*	ARE BOWEL MOVEMENTS REGULAR?*	WHAT IS USUAL TIME?*
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
WORD USED FOR "BOWEL MOVEMENT"*	WORD USED FOR URINATION*		

PARENT'S EVALUATION OF CHILD'S HEALTH

IS CHILD PRESENTLY UNDER A DOCTOR'S CARE?	IF YES, NAME OF DOCTOR:	DOES CHILD TAKE PRESCRIBED MEDICATION(S)?	IF YES, WHAT KIND AND ANY SIDE EFFECTS:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	
DOES CHILD USE ANY SPECIAL DEVICE(S):	IF YES, WHAT KIND:	DOES CHILD USE ANY SPECIAL DEVICE(S) AT HOME?	IF YES, WHAT KIND:
<input type="checkbox"/> YES <input type="checkbox"/> NO		<input type="checkbox"/> YES <input type="checkbox"/> NO	

PARENT'S EVALUATION OF CHILD'S PERSONALITY

HOW DOES CHILD GET ALONG WITH PARENTS, BROTHERS, SISTERS AND OTHER CHILDREN?

HAS THE CHILD HAD GROUP PLAY EXPERIENCES?

DOES THE CHILD HAVE ANY SPECIAL PROBLEMS/FEARS/NEEDS? (EXPLAIN.)

WHAT IS THE PLAN FOR CARE WHEN THE CHILD IS ILL?

REASON FOR REQUESTING DAY CARE PLACEMENT

PARENT'S SIGNATURE

DATE

## CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS

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### PARENTS' RIGHTS

As a Parent/Authorized Representative, you have the right to:

1. Enter and inspect the child care center without advance notice whenever children are in care.
2. File a complaint against the licensee with the licensing office and review the licensee's public file kept by the licensing office.
3. Review, at the child care center, reports of licensing visits and substantiated complaints against the licensee made during the last three years.
4. Complain to the licensing office and inspect the child care center without discrimination or retaliation against you or your child.
5. Request in writing that a parent not be allowed to visit your child or take your child from the child care center, provided you have shown a certified copy of a court order.
6. Receive from the licensee the name, address and telephone number of the local licensing office.

Licensing Office Name: \_\_\_\_\_

Licensing Office Address: \_\_\_\_\_

Licensing Office Telephone #: \_\_\_\_\_

7. Be informed by the licensee, upon request, of the name and type of association to the child care center for any adult who has been granted a criminal record exemption, and that the name of the person may also be obtained by contacting the local licensing office.
8. Receive, from the licensee, the Caregiver Background Check Process form.

**NOTE: CALIFORNIA STATE LAW PROVIDES THAT THE LICENSEE MAY DENY ACCESS TO THE CHILD CARE CENTER TO A PARENT/AUTHORIZED REPRESENTATIVE IF THE BEHAVIOR OF THE PARENT/AUTHORIZED REPRESENTATIVE POSES A RISK TO CHILDREN IN CARE.**

*For the Department of Justice "Registered Sex Offender" database, go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)*

LIC 995 (9/08)

(Detach Here - Give Upper Portion to Parents)

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### ACKNOWLEDGEMENT OF NOTIFICATION OF PARENTS' RIGHTS (Parent/Authorized Representative Signature Required)

I, the parent/authorized representative of \_\_\_\_\_, have received a copy of the "CHILD CARE CENTER NOTIFICATION OF PARENTS' RIGHTS" and the CAREGIVER BACKGROUND CHECK PROCESS form from the licensee.

\_\_\_\_\_  
Name of Child Care Center

\_\_\_\_\_  
Signature (Parent/Authorized Representative)

\_\_\_\_\_  
Date

**NOTE: This Acknowledgement must be kept in child's file and a copy of the Notification given to parent/authorized representative.**

*For the Department of Justice "Registered Sex Offender" database go to [www.meganslaw.ca.gov](http://www.meganslaw.ca.gov)*



# PARENT PHOTO POLICY

As your child participates in special events, lessons, or is just having fun on the playground, teachers and parents often have great photo and video opportunities. Our policy regarding photographing and videoing children while at school is as follows:

- Photos/Videos by parents are permitted at special events (special days, chapels, Jog-a-thon, field trips, etc.) without permission from administrators/teachers.
- Parents **should** ask permission from the teacher or administrator before taking photos/videos on the playground or in the classroom on a “regular” school day.
- Parents should exercise caution when posting photos/videos of their children (or children other than your own) on any social media outlets (Facebook, Instagram, Twitter, etc.)
- Photos/Videos taken by the teachers may be used for school purposes such as yearbook, class displays, slideshows, videos, website and school social media accounts such as Instagram or Facebook.

The safety of our students is a top priority. Our purpose in establishing and enforcing this policy is to protect your children, while still allowing you to record and preserve the sweet memories of your child’s school year.

NOTE: If you do not want photos/videos of your child taken for school purposes, please indicate that in the appropriate place.

Please check the box of choice and return this letter to the school office.

I give Los Altos Grace Schools permission to take photos/videos of my child for school purposes.

I do not want photos/videos of my child taken for school purposes.

Child’s Name \_\_\_\_\_

Grade \_\_\_\_\_

Parent Signature \_\_\_\_\_

Date \_\_\_\_\_

Sincerely,

Mrs. Debra Martin  
Elementary Principal

Mrs. Andrea Witbeck  
Preschool Director

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6565 Stearns Street Long Beach CA 90815